

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS MEDICARE INTEGRITY PROGRAM

Medical Review (Carrier and DMERC)

The Medical Review (MR) Budget and Performance Requirements (BPRs) reflect the principles, values, and priorities for the Medicare Integrity Program (MIP). Program Integrity's primary principle is to pay claims correctly. In order to meet this goal, carriers and DMERCs must ensure that they pay the right amount for covered services, rendered to eligible beneficiaries, by legitimate providers. CMS follows four parallel strategies that assist us in meeting this goal:

- Preventing inappropriate payments through effective enrollment of providers and beneficiaries;
- Detecting program aberrancies through on-going on data analysis;
- Coordinating and communicating with our partners, including contractors, law enforcement agencies, and others; and
- Reasonable and firm enforcement policies in accordance with the principles of Progressive Corrective Action (PCA).

Medical Review's primary mission is to reduce the claims payment error rate by identifying, and addressing billing errors concerning coverage and coding made by providers. The MR staff has a variety of tools to use in support of their mission. Primarily, MR reduces the error rate by identifying patterns of inappropriate billing, educating providers on medical review findings, and by performing medical review of claims.

For FY 2005, CMS is providing instructions for the MR and Local Provider Education and Training (LPET) programs, through two BPRs documents: the MR BPRs and the LPET BPRs. These BPRs will provide instructions for the MR program and MR/LPET Strategy. Carriers and DMERCs shall design one MR/LPET Strategy document that will satisfy the MR/LPET Strategy requirements for both BPRs. The carriers and DMERCs shall design the MR/LPET Strategy in accordance with Internet Only Manual (IOM) Pub. 100-8, Chapter 1. Carriers and DMERCs that conduct MR activities at multiple operational sites shall have a system in place that allows workload and funding to be tracked separately for each individual MR operational site. These carriers and DMERCs may develop only one MR/LPET Strategy. However, contractor operational site-specific problem identification, prioritization, funding, and workload shall be addressed separately in the Strategy and the Quarterly Strategy Analysis (QSA). In addition, contractor operational site-specific cost and workload information should be broken out and reported with the Interim Expenditure Report in the remarks section (or by other means with Regional Office (RO) approval) of CAFM II for each activity code (IOM Pub 100-8, Chapter. 1, section 2F).

The MR/LPET Strategy shall detail identified medical review issues, educational activities, projected goals, and the evaluation of educational activities and goals. It must

be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take precedence. The initial Strategy submitted at the beginning of the fiscal year shall be based on the Strategy from the current fiscal year and updated and expanded upon as necessary.

The carriers and DMERCs shall analyze data from a variety of sources in the initial step in updating the MR/LPET Strategy. The carriers and DMERCs shall use the Comprehensive Error Rate Testing (CERT) findings as the primary source of data to base further data analysis in identifying program vulnerabilities. Other data sources can include, but are not limited to information gathered from other operational areas, such as appeals and inquiries, that interact with MR and LPET.

After information and data is gathered and analyzed, the carriers and DMERCs shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR and LPET activities. Carriers and DMERCs shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, carriers and DMERCs shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the carriers and DMERCs shall develop MR and LPET interventions using the PCA process (IOM Pub 100-8, Chapter 3, section 14) to address each problem. The methods and resources used for the MR and LPET interventions depend on the scope and severity of the problems identified and the level of education needed to successfully address the problems. For example, for the more aberrant provider, or the provider who continues to bill incorrectly, it will be more effective to perform a site visit as opposed to simply sending a letter. In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the MR/LPET Strategy or reflected in the QSA. If resources allow, a MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the Strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims. This 0.5 FTE shall be accounted for in claims processing.

The carriers and DMERCs shall develop multiple tools to effectively address the local Medicare providers' variety of educational needs. The carriers and DMERCs shall include in their MR/LPET Strategy, achievable goals and evaluation methods that test the effectiveness and efficiency of educational activities designed to resolve targeted medical review problems. In doing such, the carriers and DMERCs shall utilize a provider tracking system that documents educational contacts, specific issue addressed, and type of intervention used. As problems are addressed, the carrier and DMERC shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the carriers and DMERCs shall use the information contained in the provider tracking system to determine a more progressive course of action. As issues are successfully resolved, the carriers and DMERCs shall continue to address other program vulnerabilities identified on the problem list.

The carriers and DMERCs shall include in their MR/LPET Strategy, a section that describes the process used to monitor spending in each activity code. The process shall ensure that spending is consistent with the allocated budget and includes a process to revise or amend the Strategy when spending is over or under the budget allocation. In addition, the Strategy shall describe how workload for each activity code is accurately and consistently reported. The workload reporting process shall also assure proper allocation of employee hours required for each activity.

Finally, the MR/LPET Strategy shall include a mechanism to monitor and improve the accuracy and consistency of the MR staff's responses to specific telephone or written inquiries regarding MR related coverage and coding issues. This is to ensure that providers receive accurate and consistent answers to their Medicare claim questions.

LPET is a critical tool in reducing the claims payment error rate. LPET should be the first action considered to address each of the problems in the problem list. Therefore, contractors may need to supplement the LPET budget with MR funds. All MR education activities are funded through LPET.

In FY 2005, MR will continue to incorporate Activity Based Costing (ABC) in the budget process. ABC is a management reporting system that will allow the MR department to focus on the costs of the work activities, instead of concentrating on the standard cost centers associated with the traditional cost accounting structure. ABC identifies the all-inclusive business process for each activity, so that the total costs of the activity are fully visible to the MR manager. Business processes are defined for each MR activity code and are included as Attachment 2 to the BPRs. MR managers shall identify only those costs associated with each activity code definition, in order to assure the integrity of the ABC process.

In addition to satisfying all requirements contained in the MR BPRs, carriers and DMERCs shall carry out all medical review activities identified in the Program Integrity Manual (IOM Pub 100-8) and all relevant MR Program Memoranda.

The carrier and DMERC shall negotiate their MR/LPET Strategy with the Regional Office (RO). Negotiations with the RO budget and MR staffs will center on the Strategy and the individual elements of the Strategy. The RO budget and MR staffs retain the authority to restrict contractor's funding amounts for MR Strategies that are not approved based on the lack of detail in methodology, inappropriate use of resources, or inappropriate selection of activities for reducing the claims payment error rate. The carrier and DMERC shall submit the approved MR/LPET Strategy to the RO. The approved Strategy shall be sent to the CMS Central Office mailbox at MRSTRATEGIES@cms.hhs.gov on the same date the Budget Request is submitted. The subject line of the e-mail containing the Strategy shall begin with the contractor name followed by "Strategy" with the identifying fiscal year and version number. Contractors will be given a specified budget for MR. Based on this budget, the contractor is asked to develop a unique MR/LPET Strategy within their jurisdiction. This Strategy must be consistent with the goal of reducing the claims payment error rate. In addition, the carrier

and DMERC shall submit to the RO business function expert and to MRSTRATEGIES@cms.hhs.gov, a QSA, 45 calendar days after the end of each quarter (IOM Pub. 100-8, Chapter 7, section 11). The QSA shall assess the accomplishments of the individual elements of the Strategy, other components of the MR/LPET process, and any necessary strategy revisions.

Activities in the MR BPRs will be reflected in updated PIM transmittals prior to the start of the fiscal year.

Discontinued MR Activities

In FY 2005, CMS will no longer fund the following activity:

CAFM II reporting for Program Safeguard Contractor (PSC) Support Services, Activity Code 21100. For those contractors that work with a MR PSC, report those costs in the Program Management line. Contractors that perform MR activities for a BI PSC shall continue to report these costs under PSC Support Services, Activity Code 23201. For support services provided to the CERT contractor, report those costs under MIP CERT Support, Activity Code 21901.

Continuing MR Activities

In FY 2005, carriers and DMERCs shall continue to perform the range of activities in IOM Pub 100-8, including, but not limited to: developing an MR/LPET Strategy, performing data analysis; conducting probe reviews; educating providers; performing the appropriate levels of prepayment and postpayment medical review; developing and revising Local Coverage Determinations (as appropriate); and supporting Program Safeguard Contractor activities (if applicable).

New MR Activities

In FY 2005, carriers and DMERCs shall begin performing the following activities:

MIP CERT Support (Activity Code 21901).

MR Activities

Instructions for completing the following quantifiable MR activities can be found in the IOM Pub. 100-8, Chapter 11. Carriers and DMERCs shall follow the instructions in the IOM Pub. 100-8, when performing and reporting the costs and workloads associated with the following activities:

Automated Review (Activity Code 21001)

IOM Pub 100-8, Chapter 3, section 4.5.
IOM Pub 100-8, Chapter 3, section 5.1.

IOM Pub 100-8, Chapter 11, section 1.3.1.

Routine Review (Activity Code 21002)

In FY 2005, begin reporting post pay routine review workload that is denied due to lack of documentation in the remarks section of Activity Code 21002. Do not include these denials in any other workload of this activity code.

IOM Pub 100-8, Chapter 3, section 4.5.

IOM Pub 100-8, Chapter 11, section 1.3.2.

Data Analysis (Activity Code 21007)

IOM Pub 100-8, Chapter 2, section 2.

IOM Pub 100-8, Chapter 11, section 1.3.

Policy Reconsideration/Revision (Activity Code 21206)

IOM Pub 100-8, Chapter 11, section 3.6.

MR Program Management (Activity Code 21207)

MR Program Management encompasses managerial responsibilities inherent in managing MR and LPET, including: development, modification, and periodic reporting of MR/LPET Strategies and quality assurance activities; planning, monitoring, and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions.

Activity Code 21207 is designed to capture the costs of managerial oversight for the following tasks:

- Develop and periodically modify a MR/LPET Strategy;
- Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, committee meetings, and periodic reports;
- Evaluate edit effectiveness;
- Plan, monitor, and oversee budget, including interactions with the contractor budget staff and the RO budget and MR program staffs;
- Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shift in workload focus when indicated;
- Implement MR instruction from Regional and/or Central Office;
- Educate staff on MR issues, new instructions, and quality assurance findings;
- PSC support services for PSCs that perform MR activities, not including the CERT contractor.

IOM Pub 100-8, Chapter 11, section 3.7.

New Policy Development (Activity Code 21208)

IOM Pub 100-8, Chapter 11, section 3.8.

Complex Probe Review (Activity Code 21220)

Report all costs associated with Prepay and Postpay Complex Probe Review in Activity Code 21220. In the workload section of CAFM II, Activity Code 21220, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the carrier and DMERC can report providers subjected to complex review, they should report this number as Workload 3.

Note: Refer to section IX "Reporting Contractor Overpayment Costs" in the general instructions. This section describes in more detail the development process of a potential Medicare overpayment and the costing of each part of the process.

Prepay Complex Review (Activity Code 21221)

Report all costs associated with Prepay Complex Review, other than probe reviews, in Activity Code 21221. In the workload section of CAFM II, Activity Code 21221, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the carrier and DMERC can report providers subjected to complex review, they should report this number as Workload 3.

Note: Refer to section IX "Reporting Contractor Overpayment Costs" in the general instructions. This section describes in more detail the development process of a potential Medicare overpayment and the costing of each part of the process.

Advance Determinations of Medicare Coverage (ADMC) (Miscellaneous Code 21221/01)

DMERCs are to report all costs associated with performing Advance Determinations of Medicare Coverage (ADMC) in Miscellaneous Code 21221/01. DMERCs are to report the number of ADMC requests accepted.

IOM Pub 100-8, Chapter 5, section 7.

Postpay Complex Review (Activity Code 21222)

Contractors must report all costs associated with Postpay Complex Review, other than probe reviews, in Activity Code 21222. In the workload section of Activity Code 21222, contractors must report the total number of claims reviewed on a postpayment basis as Workload 1 and report the total number of claims denied in whole or in part as Workload

2. To the extent contractors can report providers subjected to postpayment review, they should report this number as Workload 3.

Note: Refer to section IX "Reporting Contractor Overpayment Costs" in the general instructions. This section describes in more detail the development process of a potential Medicare overpayment and the costing of each part of the process.

MIP Comprehensive Error Rate Testing (CERT) Support

For FY 2005, CMS will provide funding earmarked for the AC to support the CERT contractor. This funding will be a "reverse auction" funding system as is found in the prior portions of the MR BPRs. The MIP CERT Support funding is over-and-above the level of funding provided to perform the MR activities listed earlier in these BPRs. Carriers and DMERCs are not required to develop a CERT Support Strategy. Carriers and DMERCs shall not include MIP CERT Support work in their MR Strategies. Carriers and DMERCs shall not shift additional funds from MR/LPET activities to this line.

In addition to satisfying all requirements contained in the MIP CERT Support section of the MR BPRs, carriers and DMERCs shall carry out all MIP CERT Support activities identified in IOM Pub.100-8, Chapter 12 and all relevant CERT Support One Time Notifications.

MIP CERT Support (Activity Code 21901)

Report the costs associated with time spent on MIP CERT Support activities. These activities include but are not limited to the following:

- Providing review information to the CERT Contractor as described in IOM Pub. 100-8, Chapter 12, section 3.3.2.
- Providing feedback information to the CERT Contractor as described in IOM Pub 100-8, Chapter 12, section 3.3.3, including but not limited to:
 - CMD discussions about CERT findings;
 - Participation in biweekly CERT conference calls;
 - Responding to inquiries from the CERT contractor; and
 - Preparing dispute cases.
- Preparing the Error Rate Reduction Plan (ERRP) as described in IOM Pub 100-8, Chapter 12, section 3.9 (Do not include costs of developing the MR/LPET Strategy. The cost of developing the MR/LPET Strategy should be captured in MR CAFM II Activity Code 21207).

- Educating the provider community about CERT as described in IOM Pub 100-8, Chapter 12, section 3.8.
- Contacting non-responders and referring recalcitrant non-responders to the Office of Inspector General as described in IOM Pub. 100-8, Chapter 12, section 3.15.

Carriers and DMERCs shall **not** report costs associated with the following activities in this activity code:

- Providing sample information to the CERT Contractor as described in IOM Pub. 100-8, Chapter 12, section 3.3.1.A&B (These costs should be allocated to the PM CERT Support Code - 12901 - described in the Appeals BPRs).
- Ensuring that the correct provider address is supplied to the CERT Contractor as described in IOM Pub 100-8, Chapter 12, section 3.3.1.C (These costs should be allocated to the PM CERT Support Code - Activity Code 12901, as described in the Appeals BPRs).
- Researching 'no resolution' cases as described in IOM Pub. 100-8, Chapter 12, section 3.3.1.B (These costs should be allocated to the PM CERT Support Code – Activity Code 12901, as described in the Appeals BPRs).
- Handling and tracking CERT-initiated overpayments/underpayments as described in IOM Pub. 100-8, Chapter 12, sections 3.4 and 3.6.1 (These costs should be allocated to the PM CERT Support Code - Activity Code 12901, as described in the Appeals BPRs).
- Handling and tracking appeals of CERT-initiated denials as described in IOM Pub. 100-8, Chapter 12, sections 3.5 and 3.6.2 (These costs should be allocated to the PM CERT Support Code - Activity Code 12901, as described in the Appeals BPRs).

MEDICAL REVIEW DELIVERABLES

<i>Report</i>	<i>Due date(s)</i>	<i>Submitted to</i>
MR/LPET Strategy <i>(Note: Contractors operating multiple MR/LPET sites are not required to submit separate reports; however, consolidated reports must clearly identify the costs and workloads attributable to each site)</i>	Submit with Budget Request	Regional Office Submit the final approved Strategy to CMS CO at MRSTRATEGIES@cms.hhs.gov (must be submitted via the VP of Government Operations)
MR/LPET Quarterly Strategy Analysis	Submit 45 calendar days after the end of the quarter	Regional Office and CMS CO at MRSTRATEGIES@cms.hhs.gov (must be submitted via the VP of Government Operations)

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS MEDICARE INTEGRITY PROGRAM

Medicare Secondary Payer - Prepayment (Carrier and DMERC)

The following Medicare Secondary Payer (MSP) Prepayment activities are listed by priority or program focus. Contractors should develop their FY 2005 MSP Prepayment budget by using the focus items outlined below. All remaining funds will be applied to ongoing MSP Prepayment workloads.

Instructions for workload reporting are included in the Activity Dictionary (Attachment 1 to these BPRs) and in Transmittal AB-03-082 (CR 2548). In general, MSP Prepayment activity workload includes all activities specific to bills on which you take some manual MSP action before the bill is paid.

These MSP actions are described in the Medicare Claims Processing Manual, Pub. 100-05, Chapters 3, 5, and 6, as well as in the specific Program Memoranda (PM) identified below. (Also reference the Activity Dictionary, Attachment 2).

Transmittal AB-02-089 (CR 1529), dated June 28, 2002; Transmittal AB-02-107 (CR 2240), dated July 31, 2002; Transmittal AB-03-016 (CR 2552), dated February 7, 2003; Transmittal AB-03-020 (CR 1558), dated February 14, 2003; Transmittal AB-03-024 (CR 2074), dated February 28, 2003; and Transmittal AB-03-082 (CR 2548), dated May 6, 2003.

MSP Bills/Claims Prepayment (Activity Code 22001)

1. Resolve MSP edits occurring in the bill adjudication process including those from the Common Working File (CWF). This does not include edits resulting from bill entry activities or incomplete bills that must be returned to the provider.

No workload or costs associated to initial bill entry should be charged to the MSP Activity Code 22001. Bill payment activities include initial claim entry and must be reported in the Program Management, Bills/Claims Payment function.

- A. Initial bill entry activities that should **not** be charged to MSP Activity Code 22001 are:

- Receipt, control of bills, and attached Explanation of Benefits (EOB)/Remittance Advice (RA). Includes opening, sorting, date stamping, imaging, Control Number assignment, batching bills, and activation of batches;
- Prepare batches for keying. Includes verification that all batches are accounted for and bills are in proper order within the batch;
- Key the entire MSP bill into the standard system to begin bills processing; and
- Resolve all bill entry edits.

- B. Initial bill entry for a MSP bill is not complete, until payment information from the primary payer's EOB/RA is keyed as part of the hard copy bill, bringing the hard copy MSP bill to the same status as the receipt of an MSP Electronic Media Claim (EMC) and preparing the bill for adjudication. Neither the hard copy bill nor the EMC should enter claim processing if the primary payment information is incomplete. The primary payment information is crucial in determining the appropriate amount Medicare should pay as the secondary payer, an amount calculated within the MSPPAY module during bill adjudication. The following list includes primary payer information that may be present on the EOB/RA or may need to be determined, then keyed, to complete entry of the hard copy bill into the standard system. All costs associated to these functions should be charged to Bills/Claims Payment.

Note: Individual EOB/RAs may use different, but similar terms.

Actual Charges	Deductible
Provider Discount	Co-pay/Co-Insurance
Contract Write-off	Non-covered Services
Primary Payer Allowed Amount	Benefits Paid
Primary Payer Paid Amount	Covered Charges
Obligated to Accept as Payment in Full	Withhold

2. Perform bill determination activities necessary to process an MSP bill through to a final payment or non-payment decision.

Examples include: comparing EOB/RA bill data to HIMR/CWF data; overriding with conditional payment codes to pay primary; making primary, secondary or denial payment decisions; working suspended bills.

3. Congressional Inquiries and Hearings related to MSP Prepayment activities.

This includes contacting the designated Coordination of Benefits (COB) contractor consortia Congressional representative, and coordinating, as necessary, for a consolidated prepay response and follow-up with the COB contractor, if applicable, after five days. This also includes contact with the COB contractor consortia for the collection of information and/or documentation to respond to a hearing pertinent to MSP Prepayment activities.

4. Prepare "I" records and add termination dates to MSP CWF auxiliary records, as necessary, to complete the bill adjudication process.

Adding "I" auxiliary records to the CWF to process a bill would include those that are necessary to accommodate an override for primary conditional payment, and also, when sufficient bill information exists to add a new CWF MSP Aux File record and process a bill as secondary.

Simple terminations should be performed when the CWF MSP Aux file was previously established on CWF with a “Y” validity indicator and no discrepancy exists with information on the active bill.

5. Prepare Electronic Correspondence Referral System (ECRS) CWF Assistance Requests and ECRS MSP Inquiries necessary to process a bill through to a final payment or non-payment decision.

ECRS transmissions that are required to complete the processing of a bill should be reported here. If the ECRS transmission is a result of an inquiry and there is no active bill in process, see requirements under Activity Code 42004, General Inquiries, for proper reporting.

MSP Workload

MSP Prepayment workload is defined in CR 2548 and the ABC Activity Dictionary.

**FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM**

Benefit Integrity (Carrier and DMERC)

Contractor budget requests should ensure implementation of all program requirements in the Program Integrity Manual (PIM) and all applicable Transmittals. The PIM, the Activity Based Costing Activity Dictionary (Attachment 2 to the BPRs) and applicable Transmittals should be referenced for instructions relating to the areas specified in these BPRs.

CONTRACTORS WHO HAVE TRANSITIONED THEIR WORK TO A PSC

Contractors who have transitioned their Benefit Integrity (BI) work to a Program Safeguard Contractor (PSC) must only use PSC Support Services, Activity Code 23201, when providing support to the PSC.

PSC Support Services (Activity Code 23201)

ACs must keep a record of support services rendered to a PSC, reporting these services in the following workloads: report the total number of miscellaneous PSC support services (e.g., training and meetings to support the PSC) in Workload 1; report the total number of PSC requests (not law enforcement related) fulfilled by the AC to support the PSC in investigations in Workload 2; and report the total number of PSC requests for support from the AC with law enforcement requests in Workload 3. Additional PSC support work that does not fall into Workload 1, 2, or 3, must be reported under this general activity code, but not counted in Workload 1, 2, or 3.

PSC Support Services - Miscellaneous PSC Support Services (Miscellaneous Code 23201/01)

ACs should report miscellaneous PSC support services (e.g., training and meetings to support the PSC) in Miscellaneous Code 23201/01.

PSC Support Services - Non-Law Enforcement Investigation Requests (Miscellaneous Code 23201/02)

ACs must keep a record of the number of requests (not law enforcement requests) they fulfill to support the PSC in investigations, and record the total costs in Miscellaneous Code 23201/02.

PSC Support Services - Law Enforcement Requests (Miscellaneous Code 23201/03)

ACs must keep a record of the number of PSC requests for support from the AC with law enforcement requests, and record the total costs in Miscellaneous Code 23201/03.

Note: Claims processing activities including adjustments, sending overpayment demand letters, etc. are not to be charged to this activity code.

CONTRACTORS WHO HAVE NOT TRANSITIONED THEIR BI WORK TO A PSC

Contractors who have not transitioned to a PSC must include the following in their budget requests: CMS training requirement; the Quality Improvement (QI) program; and the maintenance of a secure environment.

Contractors who have not transitioned to a PSC should provide the supporting documentation requested in Attachment A of the FY 2005 BPRs. Attachment A requests contractor specific narrative, workload, and cost data for FY 2004 and FY 2005.

Only contractors who have **not** transitioned their BI work to a PSC will use the activity codes listed below (23001-23015).

Medicare Fraud Information Specialist (MFIS) (Activity Code 23001)

Report all costs associated with MFIS activity in Activity Code 23001. This activity code applies only to contractors at which the Regional Office (RO) has indicated an MFIS will be located. New MFIS positions and MFIS positions vacated will not be funded.

Report the number of fraud conferences/meetings coordinated by the MFIS in Workload 1; the number of fraud conferences/meetings attended by the MFIS in Workload 2; and the number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other CMS health care partners in Workload 3.

Outreach and Training (Activity Code 23004)

Include costs associated with establishing and maintaining fraud, waste, and abuse outreach and training activities for beneficiaries and providers (excluding MFIS activities).

Report all costs associated with fraud, waste, and abuse outreach and training activities for contractor staff, providers, and beneficiaries in Activity Code 23004. Report the number of training sessions (internal and external) furnished only to BI staff in Workload 1; the number of face-to-face presentations by BI unit staff made to beneficiaries and

providers in Workload 2; and the number of training sessions furnished by the contractor BI unit to non-BI contractor staff in Workload 3.

Note: 1) a training session is the presentation of a topic regardless of the number of attendees; 2) a training session, which exceeds more than one day, is counted as one session; and 3) the same training session, which is repeated at a later date, should be counted as a separate session.

Fraud Investigation (Activity Code 23005)

Report any costs associated with fraud investigation used to substantiate a case in Activity Code 23005. Report the number of cases opened in Workload 1. Of the investigations reported in Workload 1, report how many were opened by the contractor based on contractor self-initiated proactive data analysis, in Workload 2. Report the total number of investigations closed (no longer requiring fraud investigation) and which did not become a case, in Workload 3.

Law Enforcement Support (Activity Code 23006)

For work done to support law enforcement, report all BI costs and related data analysis costs in Activity Code 23006. Report the total number of law enforcement requests in Workload 1; report the number of requests discussed with the Regional Office, in Workload 2; and report the number of BI law enforcement requests that require data analysis, in Workload 3.

Medical Review in Support of Benefit Integrity (Activity Code 23007)

Report all costs associated with medical review in support of BI activities in Activity Code 23007. Because the main goal of medical review is to change provider-billing behavior through claims review and education, any BI initiated review activity that does not allow for provider education or feedback must also be charged to this activity code. Report the number of investigations that the MR unit assisted the BI unit with, in Workload 1; the number of claims reviewed by both the MR and BI unit for the BI unit in Workload 2; and the number of statistical sampling for overpayment estimation reviews performed by MR in support of BI, in Workload 3.

Use of Extrapolation (Miscellaneous Codes 23007/01, 23007/02, 23007/03)

Contractors must keep a record of only BI work using miscellaneous codes in CAFM II for the following information: the number of consent settlements offered (Miscellaneous Code 23007/01, the number of consent settlements accepted (Miscellaneous Code 23007/02), and the number of statistical sampling performed for overpayment estimation (Miscellaneous Code 23007/03). Report workload only for the above items.

FID Entries (Activity Code 23014)

Report all costs associated with FID entries and updates in Activity Code 23014. Report the total number of new cases entered and cases that were updated in the FID in Workload 1, report the total number of new investigations entered and investigations that were updated in the FID in Workload 2, and report the total number of new payment suspensions entered and payment suspensions that were updated in the FID in Workload 3.

Referrals to Law Enforcement (Activity Code 23015)

Report all costs associated with referrals to law enforcement in Activity Code 23015. Report the total number of cases referred to law enforcement in Workload 1; report the total number of law enforcement referrals requesting additional information by law enforcement in Workload 2; and report the total number of law enforcement referrals declined in Workload 3.

Attachment A

FY 2005 BENEFIT INTEGRITY (BI) SUPPORTING DOCUMENTATION FOR CARRIERS (INCLUDING DMERCs)

Only contractors who have **not** transitioned their BI work to a PSC are required to submit the documentation on requested on this attachment.

In addition to your CAFM II budget request, CMS is requesting supporting narrative to justify your FY 2005 budget request. Please provide the information requested below.

Name of Contractor and Contractor Number Fiscal Year 2005 Budget Request Narrative and Supporting Justification

I. Staffing/Function Requirements

- What new strategies and functions will you add in FY 2005; what results do you anticipate; and what will be the cost for the functions and strategies?
- Provide new BI staffing requirements in FY 2005 and the functions the staff will perform.
- Explain any significant changes in your staffing mix or FTE level from FY 2004 to FY 2005.

Note: The total number of FTEs requested in FY 2005 for this activity should equal the number of FTEs which are calculated from productive hours entered into CAFM II.

II. Subcontracts

- Provide the following information for each subcontractor exceeding \$25,000 related to this line of your budget request (per Medicare contract, this excludes arrangements you may have with medical consultants to review Medicare claims, healthcare utilization or related services):
 - (1) The name of the subcontractor (please indicate if the subcontractor is another current Medicare contractor or a subsidiary of a Medicare contractor);
 - (2) A list of the functions the subcontractor will provide;
 - (3) The total cost you expect to incur during FY 2005, for this subcontract; and
 - (4) If available, the number of FTEs funded by this subcontract.

III. Other

- Include any additional budget narrative that supports your FY 2005 BI funding request.
- Include costs necessary to establish a secure environment as specified in the PIM, Chapter 4, section 4.2.2.6.

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS MEDICARE INTEGRITY PROGRAM

Local Provider Education and Training (Carrier and DMERC)

The Local Provider Education and Training (LPET) program is designed to support medical review by educating those providers who demonstrate erroneous claims-submission behaviors. All LPET activity supports the Medical Review (MR) program. As such, all LPET activity is a response to program vulnerabilities identified through the analysis of the Comprehensive Error Rate Test (CERT), medical review findings, information from the various operational areas of the carrier or DMERC, as well as other data from various sources. The ultimate goal of the LPET program is the continual reduction in the national claims payment error rate. Carriers and DMERCs shall evaluate the data, develop and prioritize identified program vulnerabilities, and design educational interventions that effectively address the identified problems.

Like Provider Communications (PCOM), the LPET program is intended to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. Teaching providers how to submit claims accurately, assures correct payment for correct services rendered. Unlike PCOM activities that address Medicare's national issues, LPET education is always a response to the local provider's claim submission patterns and information needs. To meet this goal, carriers and DMERCs shall use various methods, such as print, Internet, telephone, and face-to-face contacts. Simply sending a letter in response to the review of claims is not always the most effective mechanism with which to educate providers on coverage, coding, and billing errors identified by medical review.

Methodology

In FY 2005, CMS provides instructions for the MR and LPET programs through two Budget and Performance Requirements (BPRs) documents: the MR BPRs and the LPET BPRs. Carriers and DMERCs shall design one MR/LPET Strategy document that will satisfy the MR/LPET Strategy requirements for both BPRs. The BPRs provide instructions for the LPET program and MR/LPET Strategy. The carriers and DMERCs shall design the MR/LPET Strategy in accordance with Internet Only Manual (IOM) Pub. 100-8, Chapter 1. Carriers and DMERCs that conduct LPET activities at multiple operational sites shall have a system in place that allows workload and costs to be tracked separately for each individual MR operational site. These carriers and DMERCs may develop only one MR/LPET Strategy. However, site-specific problem identification, prioritization, funding, and workload shall be addressed in the Strategy and reported with the Interim Expenditure Report (IER) in the remarks section of CAFM II for each activity code (IOM Pub. 100-8, Chapter 11, section 1.2).

The MR/LPET Strategy shall address identified medical review issues, educational activities, projected goals, and the evaluation of educational activities and goals. It must be a fluid document that is revised as targeted issues are successfully resolved and other issues take precedence. The carriers and DMERCs shall analyze data from a variety of

sources in the initial step in designing the MR/LPET Strategy. A primary source of data to be used in developing the problem list is the CERT findings data. The carriers and DMERCs shall utilize the CERT findings as a starting point from which to focus additional data analysis. In addition, it is important to utilize information from other operational areas that interact with MR and LPET in order to ensure effective evaluation of all available information.

After information and data is gathered and analyzed, the carrier must develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund and can be addressed through MR and LPET activities. The Strategy shall provide the metrics used to select problem prioritization. Once a problem list is created, the carriers and DMERCs shall develop educational activities in accordance with the Progressive Corrective Action (PCA) process (IOM Pub. 100-8, Chapter 3, section 14) to address each problem. Carriers and DMERCs shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. The methods and resources used for the MR and LPET interventions depend on the scope and severity of the problems identified and the level of education needed to successfully address the problems. For example, for the more aberrant provider, or the provider who continues to bill incorrectly, it will be more effective to perform a site visit as opposed to simply sending a letter.

The carriers and DMERCs shall develop multiple tools to effectively address the local Medicare providers' wide-ranging educational needs. The carriers and DMERCs shall include in their MR/LPET Strategy achievable goals and evaluation methods that test the effectiveness and efficiency of educational activities designed to resolve targeted medical review problems. In doing such, the carrier and DMERC shall utilize a provider tracking system (PTS) that documents educational contacts, issues addressed, and types of intervention used. As problems are addressed, the carrier and DMERC shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the carriers and DMERCs shall use the information contained in the PTS to determine a more progressive course of action. As issues are successfully resolved, the carriers and DMERCs shall continue to address other program vulnerabilities identified on the problem list. CMS does not prescribe any type of mandatory configuration or format for the PTS, so long as it is capable of efficiently carrying out required functions as outlined in IOM Pub. 100-8, Chapter 3, section 1.1.

The carriers and DMERCs shall include in their MR/LPET Strategy a section that describes the process used to monitor spending in each activity code. The process shall ensure that spending is consistent with the allocated budget and includes a process to revise or amend the Strategy when spending is over or under the budget allocation. In addition, the Strategy shall describe how workload for each activity code is accurately and consistently reported. The workload reporting process shall also assure proper allocation of employee hours required for each activity.

Finally, the MR/LPET Strategy shall include a mechanism to monitor and improve the accuracy and consistency of the LPET staff's responses to specific telephone or written

inquiries regarding MR related coverage and coding issues. This is to ensure that providers receive accurate and consistent answers to their Medicare claim questions.

Clinical expertise is required to educate providers concerning coverage, coding, and billing issues related to medical review. Educational interventions shall be performed at the direction of the MR manager, clinicians, and by specially trained non-clinical staff working under the direction of the clinicians.

Budget Considerations

Carriers and DMERCs shall consider various elements when planning their LPET budget. For example, carriers and DMERCs shall explain how they plan to allocate for provider educational activities between LPET and PCOM. LPET subjects or issues include LCDs and coverage, coding, and billing issues as identified by the medical review process. PCOM issues include subjects of national scope or impact. While there are fundamental differences between the LPET and PCOM programs, there may be circumstances when it would be feasible to provide educational events that encompass the scope of both of these programs. For any functions, such as seminars, conventions, or conferences that address LPET as well as PCOM subjects, the proportional share of the cost of that function to be allocated to LPET, is equal to the percentage of time related to addressing LPET issues, multiplied by the cost of the function. For example, the proportional share of the cost of a seminar to be allocated to LPET is equal to the percentage of the seminar related to addressing issues other than PCOM subjects, multiplied by the cost of the seminar (e.g., if it costs \$4,000 to arrange and conduct a seminar containing 75 percent MR and 25 percent national coverage information, then the LPET cost would be \$4,000 multiplied by 0.75 or \$3,000, with the remaining \$1,000 charged to PCOM). However, if the intent of the educational intervention is purely LPET, but PCOM issues arise, address the issues to the extent possible, but charge the cost of the intervention to LPET. This methodology for allocating costs also applies to other general, all-purpose provider education tools or materials such as regularly scheduled bulletins/newsletters. The costs for developing, producing and distributing bulletins should be allocated proportionally, according to the percentage of time spent on each subject in the bulletin between LPET and PCOM.

Each carrier and DMERC will be given a specified maximum budget for LPET activities. Carriers and DMERCs shall identify the appropriate budget and workload, for each activity code within the constraints of their budgets. Carriers and DMERCs are not permitted to charge providers/suppliers for planned educational activities and training materials. However, carriers and DMERCs may assess fees of no more than the cost for educational activities delivered at a non-Medicare contractor sponsored event specifically requested by specialty societies or associations. In addition, although carriers and DMERCs are mandated to supply providers with a paper copy of their bulletin at no cost, upon request, carriers and DMERCs may assess a fee to cover costs if the provider requests additional copies. Any monies collected must be reported as a credit in the applicable activity code accompanied by the rationale for charging the fee. The fees must be fair and reasonable. Revenues collected from discretionary activities must be used

only to cover the cost of these activities, and may not be used to supplement other contractor activities.

Activity Codes

Business processes are defined for each LPET activity code and are included in the Activity Based Costing (ABC) Activity Dictionary (Attachment 2 to the BPRs). To accurately capture costs, the LPET ABC Activity Dictionary shall be utilized as a guide when reporting workloads. Identify only those costs associated with each activity code definition in order to assure the integrity of the ABC process. Carriers and DMERCs will negotiate workload based upon a set-funding amount.

Continuing LPET Activity Codes

- 24116 - One-on-One Provider Education
- 24117 - Education Delivered to a Group of Providers
- 24118 - Education Delivered via Electronic or Paper Media

Budget Approval Requirements

Negotiations with the Regional Office (RO) budget and MR staffs will center on the Strategy and the individual elements of the Strategy. The CMS RO budget and MR staffs retain the authority to restrict contractor's funding amounts for MR Strategies that are not approved based on the lack of detail in methodology, inappropriate use of resources, or inappropriate selection of activities for reducing the claims payment error rate.

Under the Government Performance and Results Act (GPRA), CMS has a goal to reduce the Medicare fee-for-service national paid claims error rate to 4.6 percent in FY 2005. Carriers and DMERCs are not required to establish a baseline error rate, or calculate a carrier-specific error rate to be judged against the GPRA goal. The CERT will provide the baseline measurements.

Budget requests must be accompanied by an MR/LPET Strategy that includes the following:

- A listing of information and data used to identify medical review problems;
- A listing of identified problems;
- Methodology and metrics for problem prioritization;
- An educational plan to address each problem on the list;
- Outcome goals;
- An evaluation process that assesses the effectiveness and efficiency of educational activity and measures progress towards goals;
- A system that allows for follow-up of resolved issues once goals have been met and the concurrent shifting of focus and resources to the next issue on the list;
- A list of employees identified by job title and qualification (e.g., RN, LPN, specially trained staff);

- The number of FTEs for each activity code - include direct cost and qualification (e.g., RN, LPN, specially trained staff);
- A process to monitor spending in each activity code - include a process to revise or amend the plan when spending is over or under the budget allocation;
- A workload reporting process that assures accuracy and consistency;
- A mechanism utilized to monitor and improve the accuracy and consistency of the LPET staff's responses to written and telephone inquiries regarding coverage and coding issues; and
- The following chart (for budget planning purposes only; no entry needs to be made in shaded areas):

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW (MR)					
21001	Automated Review				
21002	Routine Reviews				
21007	Data Analysis				
21206	Policy Reconsideration/Revision				
21207	MR Program Management				
21208	New Policy Development				
21220	Complex Probe Sample Review				
21221	Prepay Complex Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				
21222	Postpay Complex Review				
21901	MIP CERT Support				

LOCAL PROVIDER EDUCATION AND TRAINING (LPET)					
24116	One-on-One Provider Education				
24117	Education Delivered to a Group of Providers				
24118	Education Delivered via Electronic or Paper Media				

Activity Code Definitions

One-on-One Provider Education (Activity Code 24116)

Carriers and DMERCs shall develop One-on-One Provider Education in response to medical review related coverage, coding, and billing problems, verified and prioritized through the review of claims and/or the analysis of information. As these contacts are directly with the provider, clinical expertise is required to conduct this activity. One-on-One Provider Education includes face-to-face meetings, telephone conferences, videoconferences, letters, and electronic communications (e-mail) directed to a single provider in response to specific medical review findings. Include in this activity code the cost and workload for responding to provider questions concerning their specific medical review activities, or new or revised local policies.

Carriers and DMERCs choose the type of one-on-one educational activity based on the level of medical review related coverage, coding, and billing errors identified. For a moderate problem, the carrier may choose to educate a provider via telephone conference. For more severe problems, or a problem that was not resolved through a telephone conference, a face-to-face meeting may be more appropriate. All one-on-one contacts shall be recorded in the provider tracking system (PTS). The information to include in the PTS should be an explanation of the problem, the type of educational intervention performed, and the directions given to correct the errors. A written explanation of the problem and directions on how to correct the error might be appropriate for more severe problems, or upon provider request. While one-on-one provider education is likely to correct most medical review coverage, coding and billing errors, it may be necessary for carriers and DMERCs to provide additional remedial education if the provider's billing pattern continues to demonstrate aberrancies.

Report the costs associated with One-on-One Provider Education in Activity Code 24116. Include the cost of developing the written material used in provider specific educational activities. Written materials, or electronic communications to providers during a One-on-One Provider Education, should **not** be reported in Education Delivered via Electronic or Paper Media, Activity Code 24118. One-on-One Provider Education, Activity Code 24116, must capture the one-on-one contact between the carrier/DMERC and provider, and the written materials or electronic communication used to facilitate the one-on-one education. Included in this activity code would be letters sent to a provider that specifically addresses the medical review findings and instructions to correct the errors. Any contacts to providers made solely by paper or computer, without specifically addressing an individual provider, should not be reported here.

For One-on-One Provider Education, Activity Code 24116, Workload 1 is the number of educational contacts. Report the number of providers educated in Workload 2. If a provider sends a representative(s) on his behalf to a one-on-one educational contact, count the number of providers, not representatives, to whom the educational activity was directed.

Education Delivered to a Group of Providers (Activity Code 24117)

To remedy wide spread service-specific aberrancies, carriers and DMERCs may elect to educate a group of providers, rather than provide one-on-one contacts. Subjects more appropriately addressed in a group setting include, but are not limited to, proactive seminars regarding medical review topics, educational interventions related to a group of services that combine for a comprehensive benefit (e.g., psychotherapy services) and local provider educational needs presented by new coverage policies. This activity is not to be used to educate providers on issues of national scope. Activity Code 24117, Education Delivered to a Group of Providers, is designed to educate groups of local providers only.

Education Delivered to a Group of Providers may include seminars, workshops, and teleconferences. A differentiating factor between Education Delivered to a Group of Providers and Education Delivered via Electronic or Paper Media is live interaction between educator and providers. For example, a computer module with the capacity to educate many providers simultaneously would not be captured here, but would be captured under Education Delivered via Electronic or Paper Media. The determining factor is that there is not spontaneous, live interaction, between educator and providers, with the computer module.

Report the costs associated with Education Delivered to a Group of Providers in Activity Code 24117. Report the number of group educational activities in Workload 1. Report the number of providers educated in Workload 2. If a provider sends a representative(s) on his behalf to a group education activity, count the number of providers, not representatives, to whom the educational activity was directed.

Education Delivered via Electronic or Paper Media (Activity Code 24118)

Carriers and DMERCs may elect to provide education via electronic or paper media. Do not report here an electronic tool or a paper document developed and utilized as an adjunct to One-on-One Provider Education (Activity Code 24116), or Education Delivered to a Group of Providers (Activity Code 24117). Instead, report education delivered solely by electronic or paper media that does not involve the facilitation or interpretation of a live educator. A comparative billing report issued to an individual provider during a one-on-one educational activity that included instructions on curing aberrant practices is an example of a paper tool used by the educator, and therefore would not be captured here. It would be included in the One-on-One Provider Education (Activity Code 24116) because it was an adjunct paper tool. A written letter composed by an educator containing specific instructions to an individual provider would also be considered One-on-One Provider Education. However, comparative billing reports issued to specialty groups upon request, or posted on the Web as a means to illustrate patterns, would be captured here.

Carriers and DMERCs are required to maintain a Web site. Included in this category are developing and disseminating medical review bulletin articles. In addition, carriers and

DMERCs are required to submit to CMS those articles/advisories/bulletins that address local coverage/coding and medical review related billing issues (IOM Pub. 100-8, Chapter 1, section 5.A.9). Frequently asked questions (FAQs) are part of Education Delivered via Electronic or Paper Media as well. Carriers and DMERCs are required to update them quarterly and post them to their Web sites. Carriers and DMERCs are encouraged to develop FAQ systems that allow providers to search FAQ archives and subscribe to FAQ updates. The CMS requires contractors to forward all articles and FAQs to CMS per the instructions in IOM Pub. 100-8, Chapter 1, section 5.A.9. Another example of Education Delivered via Electronic or Paper Media, includes, but is not limited to, scripted response documents to LCDs and coverage review questions to be utilized by the customer service staff.

Report the costs associated with Education Delivered via Electronic or Paper Media in Activity Code 24118. Report the total number of educational documents developed for use in non-interactive educational documents in Workload 1. Report the number of CBRs developed in Workload 2 (do not include CBRs developed for activities in 24116 and 24117). Report the number of articles/advisories/bulletins developed in Workload 3. Workloads 2 and 3 are subsets of Workload 1.

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS MEDICARE INTEGRITY PROGRAM

Provider Communications (Carrier)

The aim of the Provider Communications (PCOM) program for FY 2005, continues to be based on CMS' goal of giving those who provide service to beneficiaries, the information they need to: understand the Medicare program; be informed often and early about changes; and, in the end, bill correctly. Provider Communications is driven by educating providers and their staffs, about fundamental Medicare programs, policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and by analyses of provider inquiries and claim submission errors.

Provider Communications uses mass media, such as print, Internet, satellite networks, and other technologies, face-to-face instruction, and presentations in classrooms and other settings, to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. Provider communications work using the Internet and electronic communications is funded through the Program Management (PM) budget.

The PCOM staff should also consult with the Medical Review staff and the Contractor Medical Director to determine if PCOM is needed to address national educational activities, including national policies and national coverage/coding issues. Unlike Local Provider Education and Training (LPET), PCOM is generally not targeted to individual providers, but is instead designed to be broader in nature, plus have an additional focus on:

- New programs, policies and initiatives;
- Educating providers on significant changes to the Medicare program;
- Training and consulting for new Medicare providers; and
- Ongoing education of billing staff.

The Provider Communications instructions in the Contractor Beneficiary and Provider Communications Manual, Pub.100-09, Chapter 4, section 30, represent the current requirements for carriers. No new or incremental work is proposed under these BPRs for FY 2005.

Activity Based Costing (ABC) will again be used in the budget process for Provider Communications. The Provider Communications work components from the Manual and both PCOM BPRs, are grouped within and under the ABC definitions.

FY 2005 Funding Approach

For FY 2005, CMS will fund each contractor's level of effort to provide excellent educational services. Each contractor will be given a specified maximum budget for

PCOM activities. Based on this budget, the contractor must develop a plan for conducting educational activities in their area.

Contractors should explain how they plan to allocate costs for provider education activities between PCOM, LPET, and Benefit Integrity (BI). LPET subjects or issues include, but are not limited to, medical review, LMRPs, and local coverage and coding issues related to medical review. BI subjects include fraud and abuse and benefit integrity. For any functions such as general seminars, conventions, or conferences that address PCOM subjects, as well as LPET and/or BI issues, the proportional share of the cost of that function to be allocated to PCOM is equal to the percentage of time related to addressing PCOM Medicare issues multiplied by the cost of the function. This methodology for allocating costs also applies to other general, all-purpose provider education tools or materials, such as regularly scheduled bulletins/newsletters. The costs for developing, producing and distributing bulletins should be allocated proportionally according to the percentage of subject contents of the bulletin between PCOM, LPET, and BI.

Following are the FY 2005 activities, their activity code numbers, and accompanying manual references for the ongoing work requirements included under the activity.

Create/Produce and Maintain Educational Bulletins (Activity Code 25103)

Reference: IOM, Pub.100-09, Chapter 4, section 30.1.5.

No new or incremental work proposed for FY 2005.

Workload 1 is the total number of bulletin editions published. Workload 2 is the total number of bulletins mailed.

Partner with External Entities (Activity Code 25105)

Reference: IOM, Pub.100-09, Chapter 4, section 30.1.12.

No new or incremental work proposed for FY 2005.

Workload 1 is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee.

Administration and Management of PCOM Program (Activity Code 25201)

Reference: IOM, Pub.100-09, Chapter 4, sections 30.1.1, 2, 3, 10, 11 and 20.2.1.

No new or incremental work proposed for FY 2005.

Workload 1 is the number of provider inquiries referred to the provider communications area requiring technical experience, knowledge or research to answer.

Develop Provider Education Materials and Information (Activity Code 25202)

Reference: IOM, Pub.100-09, Chapter 4, section 30.1.14.

No new or incremental work proposed for FY 2005.

Workload 1 is the number of special media efforts developed.

Special Media Creation (Miscellaneous Code 25202/01)

Use Miscellaneous Code 25202/01 to report the costs associated with the preparation of special media.

Disseminate Provider Information (Activity Code 25203)

Reference: IOM, Pub.100-09, Chapter 4, section 30.1.6, 8, 9, and 13.

No new or incremental work proposed for FY 2005.

Management and Operation of PCOM Advisory Group (Activity Code 25204)

Reference: IOM, Pub.100-09, Chapter 4, section 30.1.4.

No new or incremental work proposed for FY 2005.

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS MEDICARE INTEGRITY PROGRAM

Medicare Secondary Payer - Postpayment (Carrier and DMERC)

The BPRs for FY 2005 detail specific workload focus items in addition to ongoing Medicare Secondary Payer (MSP) Postpayment activities. Contractors should develop their FY 2005 MSP Postpayment budget by using the workload focus items outlined in the narrative below only. MSP outreach will not be funded.

In general, these MSP activities are described in the ABC Activity Dictionary (Attachment 2 to the BPRs), the Internet Only MSP Manual, Pub. 100-5, and the Financial Management Manual, Pub. 100-6, as well as the specific Program Memoranda (PMs) identified below:

Transmittal AB-00-11 (CR 899), Transmittal AB-00-129 (CR 1460), Transmittal AB-03-082 (CR 2548), CR 3274 - Financial Management (awaiting publication), CR 2870 - Financial Management (awaiting publication), Transmittal 86 (CR 3142) and CR 3163 calculations (awaiting publication). Additionally, the 04/15/03, Joint Signature Memorandum titled "Clarification/ Reminder of Medicare Secondary Payer (MSP) Post Payment Activities for FY 2003 for Group Health Plan (GHP) Recoveries" and the 1/30/2004, Joint Signature Memorandum titled "Expanded Aetna/CIGNA litigation Exclusions."

General Reminder: The BPRs will not override any postpayment instructions where contractors have specific instruction for pending litigation, bankruptcy, etc.

The following MSP Postpayment activity codes are listed in order of workload focus priority. Contractors should **only** budget for these focus workloads.

Group Health Plan (Activity Code 42003)

1. Fully implement and become current on the identification and initial demand letter process involving all Data Match cycle tapes. History search parameters should be from 10/1/01 forward. If the history search identifies potential GHP mistaken primary payments that equal or exceed \$1,000, the contractor must seek recovery. Prior to the mailing of an initial demand, check the Common Working File (CWF) to determine the records validity to the proposed debt. The initial demand letter for Data Match GHP should be sent by certified mail. Upon issuance of the demand letter packages, the contractors should provide a copy of the demand letter packages to the insurer/Third Party Administrator (TPA) associated with this debtor (employer). The copy to the insurer/TPA does not have to be sent by certified mail. The contractor should also obtain authorization

from the debtor to allow the insurer/TPA to act as their agent in resolving the debt.

2. Fully implement and become current with the Non-Data Match GHP mistaken payment identification and initial demand letter process. History search parameters should be from 10/1/01 forward. If the history search identifies potential GHP mistaken primary payments that equal or exceed \$1,000, the contractor must seek recovery. Prior to the mailing of an initial demand letter, check the CWF to determine the records validity to the proposed debt. The initial demand letter for Non-Data Match GHP should be sent by certified mail. Upon issuance of the demand letter packages, the contractors will provide a copy of the demand letter package to the insurer/TPA associated with this debtor (employer). The copies do not have to be sent by certified mail. The contractor should also obtain authorization from the debtor to allow the insurer/TPA to act as their agent in resolving the debt.

Note: If the GHP on the original demand has a “union plan”, the lack of CWF information for the debt is not a sufficient reason to invalidate the debt.

3. Acknowledge and respond to 95% of all correspondence within 45 calendar days from the date of receipt in the corporate mailroom or any other mail center location, absent instructions to the contrary for a particular activity. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.

Liability, No-Fault, Workers’ Compensation (Activity Code 42002)

Carriers/DMERCs will have no workload specific to 42002. All activities for which the carrier and/or DMERC had non-lead responsibility are the lead recovery intermediary’s responsibility. ReMAS functionality will eliminate the need for non-lead interactions.

Debt Collection/Referral (Activity Code 42021)

1. Adjudicate and post all checks to established debts within 20 days from receipt on the corporate mail center. The goal is to post all checks to an established debt within the same quarterly reporting period.
2. Acknowledge and respond to 95% of all correspondence within 45 calendar days from the date of receipt in the corporate mailroom or any other mail center location, absent instructions to the contrary for a particular activity. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.
3. Refer all eligible debt to Treasury within required timeframes in compliance with CMS instructions.

4. Upon issuance of the intent to refer letter, the contractor should provide a copy of the entire intent to refer package with all attachments to the insurer/TPA of the debtor (employer). The copies do not have to be sent by certified mail.

General Inquiries (Activity Code 42004)

1. Deposit checks and transmit ECRS MSP Inquiries on all voluntary/unsolicited checks not associated with an existing case or debt in order to begin the development process at the COBC, as defined in CR 3274.
2. Acknowledge and respond to 95% of all correspondence within 45 calendar days. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.

MSP Workload

MSP Postpayment workload is defined in CR 2548 and the ABC Dictionary.